Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3962

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-07-6550-01

MFDR Date Received
JUNE 4, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim presented by Texas Orthopedic Hospital was billed in the same manner and at the same rates that it would bill any health plan or insurer. There is no evidence provided by the carrier that its Explanation of Payment contains any verifiable information to contradict the information supplied by Texas Orthopedic Hospital. The issuance of an Explanation of Payment is not evidence of an audit or anything else. It is nothing more than a carrier's, or an adjuster's substitution of figures that it likes better than the claim presented… Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%. Per Rule 134.401(c(6)(A)(v), the only charges that may be deducted from the total bill are those for personal items… and those not related to the compensable injury… Therefore, reimbursement for the entire admission including charges for items in (c)(4) is calculated by the stop-loss reimbursement factor stated in ACIHFG, i.e., 75%... Therefore, the fees paid by Zurich American Insurance Company do not conform to the reimbursement section of Rule 134.401."

Amount in Dispute: $60,619.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated June 22, 2007: "Medical bills in excess of $40,000 do not automatically qualify for stop-loss reimbursement. Rather, the per diem rate is the default and preferred method of reimbursement that must be employed unless the hospital justifies use of the stop-loss method in a particular case… To qualify for stop loss, the services provided by the hospital must be unusually costly to the hospital as opposed to unusually priced to the carrier. The services provided by the hospital (not by a physician attending a patient while in the hospital) must be unusually extensive. Exceptional cases will be entitled to reimbursement under the stop loss exception. There is no evidence submitted by the hospital demonstrating that the services provided by the hospital were unusually extensive. There is no evidence of 'complications, infections, or multiple surgeries' requiring additional services by the hospital."

Respondent's Supplemental Response dated September 12, 2011: The extraordinary payment allowed under the stop-loss exception was designed with the expectation that it would be sparingly used… Requestor must prove the hospital admission required unusually extensive AND unusually costly services… Both the Respondent and the Division are charged with applying DWC audit rules to this admission… Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be

awarded in accordance with the general per diem payment in accordance with 28 Tex. Admin. Code § 134.401 (repealed). Otherwise, the Division should determine the proper audited charges in accordance with Division audit obligations and rules.

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2006 through July 1, 2006	Inpatient Services	$60,619.58	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 226 – Included I global charge.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 97 – Payment is included in the allowance for another service procedure.
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - No documentation to support unusually extensive service for stop loss criteria.
   - Reviewed by medical specialty services reconsideration denied..

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 824.8. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor seeks reimbursement at the Stop-Loss percentage of 75% of billed charges based upon "Therefore, reimbursement for the entire admission including charges for items in (c)(4) is calculated by the stop-loss reimbursement factor stated in ACIHFG, i.e., 75%."
- The requestor did not provide documentation to demonstrate how it determined that full reimbursement of billed charges was fair and reasonable.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 6, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	December 6, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.